

**National Ethics Teleconference
Influenza Pandemic Preparedness Planning: Ethics Concerns
June 27, 2006**

INTRODUCTION

Dr. Berkowitz:

Good day everyone. This is Ken Berkowitz. I am the Chief of the Ethics Consultation Service at the VHA National Center for Ethics in Health Care and a physician at the VA NY Harbor Healthcare System. I am very pleased to welcome you all to today's National Ethics Teleconference. By sponsoring this series of calls, the Center provides an opportunity for regular education and open discussion of ethical concerns relevant to VHA. Each call features an educational presentation on an interesting ethics topic followed by an open, moderated discussion of that topic. After the discussion, we reserve the last few minutes of each call for our 'from the field section'. This will be your opportunity to speak up and let us know what is on your mind regarding ethics related topics other than the focus of today's call.

PRESENTATION

Dr. Berkowitz:

Now let's begin today's discussion. I'm sure that most of you are aware that earlier this year VA released its pandemic influenza plan. That plan describes how the Department of Veterans Affairs will protect employees and the veterans we serve, maintain continuity of operations, communicate with stakeholders, and support and coordinate with Federal, national, state, local, and tribal efforts. This document has been added to existing VA emergency plans to assist all parts of the Department with preparation, response, and recovery stages in the event of an influenza pandemic. We included the link to this document and references to some ethics-relevant sections in the reminders for this call. For those of you who have had a chance to look at the VA Pandemic Influenza Plan, you are aware that it is itself a planning document. There is still a lot that needs to be done at the national and local levels to put things into place for a coordinated response.

In support of the plan and communication efforts about it, we wanted to use this call to do four things:

1. To discuss ethics concerns related to flu preparedness and response.
2. To let you know about the National Center for Ethics' Initiative in concert with the Department of Health and Human Services to develop national ethics guidance regarding allocation of scarce resources and altered standards of care in a pandemic flu epidemic

3. To solicit information from the field to inform development of this national guidance, and
4. To suggest steps that facilities might take over the next few months to begin a dialogue about ethics concerns related to pandemic flu.

Our goal in today's call is *not* to provide answers to the ethics questions raised by pandemic flu or to offer guidance on allocation of scarce resources. We intend for those answers and that guidance to come later this year. Instead, we want to use today's call as an opportunity to get us thinking together about some of the issues that emerge for health care providers and patients in a public health emergency such as pandemic flu.

Joining me on today's call is :

Doctor Virginia Ashby Sharpe. Ashby has her PhD in philosophy and is a Medical Ethicist at the National Center for Ethics in Health Care. She is heading up the Center's Pandemic Flu Ethics Initiative

Thank you for being on the call today.

With that, Ashby can you begin by setting the context for us?

Dr. Sharpe:

Sure, thanks Ken. I also want to acknowledge the various roles that you're playing in pandemic flu preparedness – as a member of the Center's Pandemic Influenza Ethics Initiative, the VISN 3 Influenza Pandemic Planning Task Force and the New York State Department of Health Task Force on Ventilator Allocation in an Influenza Pandemic.

Dr. Berkowitz:

That's right, Ashby. Were working on a lot of different fronts to address ethical issues regarding pandemic flu. Go ahead and get us started with some context.

Dr. Sharpe:

Okay. As Ken mentioned, in March of this year, the VA released its Pandemic Influenza Plan as part of the National Strategy for Pandemic Influenza. The VA plan supports the national goal of preparedness and communication by laying out the variety of steps that VA will take to protect its staff and the veterans we serve, to maintain operations, to cooperate with other organizations, and to communicate with stakeholders.

Dr. Berkowitz:

Thanks, Ashby. It's also important to point out that although the plan is flu-specific, a lot of the thinking about preparedness will likely be applicable to other scenarios that might stress our system (e.g., other pandemics, natural disasters, manmade disasters, etc.). That having been said, can you tell us about the H5N1 strain of influenza?

Dr. Sharpe:

The National Strategy and all other pandemic flu planning right now is a response to concerns that the serious outbreak of the H5N1 strain of *avian* influenza among birds in Asia and now Europe may eventually cross the species barrier resulting in cross infection from bird to human and subsequent mutation of the avian virus into a form that is highly infectious for humans and spreads easily from person to person.

H5N1 is a new strain for humans, which means that there is no natural immunity. To date roughly 225 people – mostly those who have direct contact with poultry -- have been infected by H5N1. There is no evidence that the H5N1 virus has mutated into a form that would be highly contagious among humans.

According the World Health Organization, although neither the timing nor severity of the next pandemic can be predicted, “the risk of pandemic influenza is serious. With the H5N1 virus now firmly entrenched in large parts of Asia... each additional human case gives the virus an opportunity to improve its transmissibility in humans, and thus develop into a pandemic strain.”

Just to be clear, a pandemic flu outbreak raises a special set of ethical concerns because the clinical demands of a surge are expected to be significantly over capacity. There will be more sick people, who have more complications, and who need more supportive care – all in an environment where contact can increase the spread of the virus.

Dr. Berkowitz:

Thank you, it's helpful to be clear about what's at stake in a pandemic and also to differentiate the avian flu from a human pandemic. We should also point out that a flu pandemic is separate from the flu virus that we prepare for annually.

Let me take a few minutes to give a brief overview of ethics concerns related to influenza pandemic preparedness planning.

In the supporting material for today's call, we provided a brief list of the ethics issues raised in the VA Pandemic Flu Plan – keyed to the relevant sections of the plan. These 5 issues include:

Two issues that relate to professionalism and our overall environment:

- Health care professionals' duty to care for the sick – even if it is at their own peril or inconvenience, and
- VHA's reciprocal obligations to health care professionals – our staff deserve the system's best efforts to minimize the peril that they face when performing their duties

Two ethics issues that will confront the system if it faces a surge in demand beyond what could ordinarily be expected:

- Criteria and processes for allocation of scarce resources such as in-patient beds, ventilators, and personal protective equipment, masks, and
- Agreements regarding altered standards of care including possible clinic closure and postponement of otherwise needed care

Finally, we must recognize our obligation to use processes that promote:

- Transparency in communication and decision making throughout our planning and implementation.

Ashby, could you get us started in thinking about the ethical issues raised in these areas by pandemic flu preparedness?

Dr. Sharpe:

Sure Ken. As in any public health emergency, many of the ethical issues relevant to pandemic flu stem from the need to place limits on individuals in order to promote the public health. But this is even more acute where contagious disease is concerned and the surge of disease is expected to overtax existing resources.

For example, regarding the duty to care, health care providers may be expected to work outside their normal scope of practice, expose themselves to risk of infection and put in extra hours that may separate them from their families.

The reciprocal obligation of VHA to support providers who face a disproportionate burden in caring for patients will require coordination of available inventories according to criteria that give priority to these groups. Such protections, for example, mandatory vaccinations for health care providers may also require impinging on the liberties of those who would refuse.

Regarding allocation of scarce resources, the circumstances of a flu pandemic, like the SARS outbreak in 2003, present special ethical challenges to health care providers. Under *ordinary* circumstances, health care providers have a fiduciary obligation to promote the welfare of individual patients. Under the *extraordinary* circumstances of a pandemic, health care providers will need to make difficult

decisions about how best to use a scarce resource to meet overwhelming needs – and this may mean denying services that are not expected to enhance survival or limiting access to elective care in order to prevent the spread of contagion.

The shift from a focus on individual to public welfare is at the heart of altered standards of care that may need to be put into place to make best use of resources during the extraordinary circumstances of a flu pandemic.

A flu pandemic may result in mass victims and a demand for health care services that is beyond the surge capacity of VHA facilities – that is, the resources in excess of those used on a daily basis. Such emergency circumstances require a shift from a traditional focus on individual patient need to decision making that is geared to the best use of scarce resources such as beds, equipment, supplies, and personnel.

Importantly, there are different ethical perspectives on what would constitute the “best use of scarce resources” -- including a utilitarian maximization of lives, a humanitarian prioritization of the sickest salvageable patient first, or a combination of utility and equity that would give priority to the sickest first, if and only if they have a good chance of recovery.

Regarding transparency, the circumstances of a pandemic will raise controversial questions about limit-setting and restrictions on individual freedom. Because answering such questions involves competing and sometimes conflicting values, transparent processes for decision making can be the basis for mutual understanding and trust in the achievement of fair outcomes.

Ken, maybe you could give an overview of the Center’s plan to develop national guidance.

Dr. Berkowitz:

Sure. To address some of these ethical issues, we at the National Center for Ethics in Health Care have begun a process to work in concert with HHS to develop national ethics guidance regarding allocation of scarce resources and altered standards of care in a pandemic flu. Our plan is to develop the guidance over the next six months or so for distribution to VHA facilities. It will be based on work being directed by HHS and will be produced by the Center with the help of a steering committee composed of people from the field and central office.

The scope of the ethics guidance is limited to decisions that will be made within VHA facilities. It will not, for example, provide primary guidance for decisions about mandatory quarantine, or vaccine prioritization that will be made by federal or state public health authorities.

Dr. Sharpe:

Again, our ethics guidance is premised on the fact that although all enrolled patients have an equal claim to receive the health care they need under normal conditions, during a pandemic, difficult decisions will need to be made about which health services to maintain and which to curtail, defer, or deny. Depending on the severity of the health crisis, this could curtail not only elective surgeries or maintenance and preventive care, but could also limit the provision of some acutely necessary services.

Dr. Berkowitz:

As part of our work we anticipate needing to address some very difficult and central issues such as:

1. Clear determinations, ideally based on clinical algorithms, about those conditions that would not benefit from a particular scarce resource.
2. Clear triage criteria.
3. Consistency in the application of the allocation criteria whether patients are sick with flu or any other condition.
4. The relationship between stopping treatments and not providing treatments, when each are expected to result in an adverse outcome for the patient.
5. Transparent processes for making particular allocation decisions.
6. Maintaining an emphasis on humane and respectful care even when services and access must be limited.

Dr. Sharpe:

Thanks Ken, and of course, as we move forward, this list of key issues will grow. In the service of that effort, we'd like to use this call as an opportunity both to acknowledge and to learn about similar work already underway at VHA facilities.

Since the release of the VA Pandemic Influenza Plan, we have received a number of consult requests from the field regarding allocation of scarce resources during flu pandemic. The guidance that we're developing is intended to respond to those concerns.

Also, we know that many of you are already grappling with these issues for your local plans. We've heard from Dr. Ware Kushner, Director of Pulmonary Rehab at Palo Alto that his facility has begun to draft guidance on allocation issues and altered standards of care and he has kindly shared that with us – and we're sure that many others are also working on these issues.

As we've said, one of the aims of our efforts is to be inclusive, so for those others who are working on ethics guidance in their local plans, please let us know by sending an email to vhaethics@va.gov. We'd love to consider what you're thinking while we develop our national guidance. That e-mail again is vhaethics@va.gov.

Dr. Berkowitz:

Now that we've laid the groundwork, we'd like to open the discussion to participants on this call who are also working on ethics guidance in their local plans, or who have particular ethics questions or concerns about pandemic flu or the guidance we will be developing. I'll try to be a little more prescriptive than usual as I moderate this portion of the call since time is limited and we have some particular questions that we would like your responses on.

So rather than having one general discussion, what I'd like to do is use about the next fifteen minutes for three mini discussions – 5 minutes each about questions in three categories relating to resource allocation, altering standards of care and some components of professionalism. Let's consider some of the resource allocation decisions. Let's use mechanical ventilators as a specific example since they are an important finite resource that is likely to be rationed in a flu pandemic. Consider or are you aware that you might have to triage your ventilators? Have you started to think about how you'd make these decisions? Are there suggestions for criteria to use, etc? Any questions or comments about rationing ventilators?

One question that has specifically come up is if we are in a situation of rationing ventilators, will people be able to equate withholding the ventilator from withdrawing the ventilator? So if there is a specific triage criteria, would someone who is already on the ventilator have it removed just the same as someone who needed it wouldn't have it started. Any thoughts about that?

Caller:

Well I have an additional comment. There is a device available that costs \$55 each and is presently being used for transport. The device is able to be hooked up to an oxygen cylinder and you can run eight vents off of it. Are you aware of that?

Dr. Berkowitz:

Well certainly before we would get into any situation of rationing, every effort would have to be made to try to redistribute patients if possible and augment the care that would could provide. I think that any devices that we could find to augment our ability not to have to ration or deny patients a ventilator if they

needed it is very welcome. From my work on the New York State Task Force, I know that there have been a lot of suggestions about scaled back ventilators and ventilators that don't have all the bells and whistles that may be available and there's been some consideration of devices like you've mentioned. I don't know specifically the ones you are talking about but unfortunately many feel that a lot of the ones that are touted simply won't work. But the take home message is that we need to do everything we can to augment our supply before we limit.

Caller:

That particular device would allow for maintenance and would be a lower standard of practice because right now they are not authorized for therapeutic use, only for transport. But they are able to be used in the event of an emergency. That costs and you would have a rate volume regulator that could save lives.

Dr. Berkowitz:

If you have specifics about it, email it to us at [vhaethics](mailto:vhaethics@outlook.com) on the Outlook system and I'd love to take a look at that. But back to the ethics question at hand about if we do have to make these ventilators triage decisions, where do people think in the facility that those triage decisions should be made? Should it be between the individual practitioner and their patients? Should it be the ICU Chief, Hospital Administrator, or some sort of a committee? How do people envision that that might work?

Dr. Ware Kushner, Palo Alto:

I am Chair of the Clinical Bioethics Committee here and first of all hats off to you and Ashby for doing a great job for setting the table for this continuing dialog and discussion about a real tough topic.

Dr. Berkowitz:

Thank you.

Dr. Ware Kushner, Palo Alto:

And thank you for mentioning my name. In fact we are working incrementally in developing the tenants and procedures that will help take us through a pandemic influenza should we have the misfortune of experiencing one. What we are and have developed here at Palo Alto is a triage and scarce resource allocation team, at least in principle, that would have a very significant role in overseeing and guiding issues regarding triage and scarce resource allocation including mechanical ventilation. So we envision a scenario where the autonomy of individual providers to make decisions about individual patients is curtailed and

we would hope that intensivists for instance and emergency department physicians would be working in a close collaborative fashion with this triage and scarce resource allocation team which would have a broader perspective of the immediate needs and be able to anticipate evolving needs in a disaster or pandemic flu. So we do see a role for broad representation in terms of making what may very well be life and death decisions for individual patients.

Dr. Berkowitz:

Thank you Ware. Does your group or anyone else who would like to comment, address the concept that if you're going to make a decision about people who are not eligible for the ventilator, do you consider not starting the same as stopping the ventilator?

Dr. Ware Kushner, Palo Alto:

I think many commentators and ethicists have written that there should be no ethical distinction between withholding and withdrawing support. Though I think we all recognize emotionally that is quite something different often than in principle. So withdrawing support certainly I think is a little bit more challenging than withholding and allocating support to another needy patient.

Dr. Sharpe:

Ware can I jump in and ask you if your committee has a mechanism for appeals for decisions that are made to restrict services or forms of care?

Dr. Ware Kushner, Palo Alto:

That's a great comment or question. As currently construed, I would characterize as a policy in evolution, it does not. I think one of the things that we are strongly advocating is that there is complete and comprehensive review of everything that unfolds during a pandemic after it is over but to get back to your question about real time appeal mechanisms, as currently construed, we don't have a formal mechanism for doing that. Having said that as we have developed our triage and scarce resource allocation team, one of the critical representatives on that would be a member of our health care system ethics committee. We envision the function of that member to provide guidance on resolving ethical conflicts disputes and dilemmas and that this person should, in fact, have an oversight role or serving as an ethical check to make sure the tenets that we've outlined that should guide the actions of the team, that those very tenets are being followed and observed very closely as the team functions in real time. So we would sort of a real time ethical check and we believe we have the mechanism in place. We don't have any formal appeal mechanism beyond that.

Dr. Sharpe:

That's very helpful. So there's accountability built into the way the committee is structures. The ethicist wouldn't be a voting member of the committee but would have more of an oversight function?

Dr. Ware Kushner, Palo Alto:

That is correct.

Dr. Sharpe:

Thank you.

Dr. Berkowitz:

It's interesting. Ashby and I have been talking about this a lot during the past few days and it's my opinion and it is just my opinion that there needs to be some sort of due process or appeal mechanism at least to assure that the processes that are in place are being fairly and consistently applied. And it sounds like that's your intent with that protection there.

Let's move on a little bit to start to think about some questions about altering our standards of care. One caller also said that we may have to lower our standards of practice to use a device that is only approved for transport but we may have to try it for care. And we recognize if our system is stressed beyond capacity. We may need to curtail, defer or temporarily deny services that we normally would provide. And we're trying to come up with a rubric whereby such decisions would be made and implemented. I was wondering how people thought about that.

Caller:

One issue for me is the standards of care both institutional as well as professional. By presuming that we have other than medical criteria for making these decisions, we've already begun to add other criteria that aren't traditionally used in making medical decisions. So I think one of the processes that has to be addressed is really the institutional decision making and ethic.

Dr. Berkowitz:

Tell me more about what you mean.

Caller:

I'm just struck by the fact that we've now got an ethicist being talked about as having the luxury of time to think through some of these decisions and that would introduce other than, perhaps, medical criteria for making the decision. It's kind of like the issue of the old days when people were to go on dialysis machines. Is that the situation?

Dr. Berkowitz:

I don't think what Dr. Kushner is talking about or I'm envisioning is anything that needs the luxury of time. I think what we're talking about is a group that in real time is going to try to implement criteria fitting the situation. And I think everyone recognizes that if you have five people with respiratory failure say and you have two ventilators, you need to have thought about it ahead and then say okay, one and two get the vents, three, four, and five don't, and then try to figure out what happens to three, four, and five. That's the unfortunate reality.

Caller:

Again I think that's an institutional ethical decision as well and maybe that's why you've got a multidisciplinary committee. But its medical criteria that are going to be applied which is going to be standard of care right there.

Dr. Berkowitz:

But I think that there's a lot of debate about what medical criteria should be applied.

Dr. Sharpe:

For example, certain clinical algorithms might not have been developed to make any clear determination on the basis of strictly clinical criteria. And inevitably those clinical criteria, as Ken was saying, will be made in a context of resource scarcity which already introduces a host of ethical values and the question is do we want to make those difficult ethical decisions explicitly or do we want to leave them implicit in a process that may not have any accountability. And we're arguing for a more explicit process based on clear criteria that have been developed both for use at the institutional level and any other levels where they may be needed.

Alan Jones, Albuquerque, NM:

I think one of the concerns and issues that we might want to be thinking about is other co-morbidities that would prevent the patient from coming back off the ventilator like a complex COPD patient that if we placed him on the ventilator the COPD is going to compound us getting him back off that ventilator as much as the pandemic flu.

Dr. Berkowitz:

And I think that a lot of the triage rubrics that are being put forward obviously start by looking for cases where applying the resource, say the ventilator, wouldn't help the person. And those people wouldn't be eligible again. Most people may believe that if you're on it and it's not going to help you, you need to come off it or if it's not going to help you, we're not going to start it. And that does totally change our standard of care in our normal shared decision making and informed consent requirements. But I think then that the next level down from those obvious cases of medical futility or near futility, are the cases like you're suggesting where the patients are predicted to either less likely benefit from the resource or need to use it for a longer period time than we're comfortable with given it's scarcity. And that's really very difficult one to predict and two to apply fairly because many of the co-morbidities that you're talking about disproportionally affect different vulnerable groups in society. So excluding people with certain co-morbidities is in a sense excluding vulnerable populations from eligibility for life saving treatment. Any thoughts on that complicating line of reasoning?

Dr. Ware Kushner, Palo Alto:

I would sort of amplify those challenges that you are explaining about vulnerable populations by throwing out an ethical challenge if you will. And that is a scenario where if we are following the ethical precept of utilitarianism or welfarist-consequentialism where we want to do the maximum good for the maximum number of patients, which I think has been in the setting of pandemic flu, been interpreted as maximizing the number of lives saved. A counter argument might be: should we be trying to maximize the amount of life (life years) saved and I'll give an example. We may be faced in a situation where we can save for instance, x number of 40 year olds who would otherwise be healthy and might have a life expectancy of another 45 years but for the fact that they have influenza or we could save the lives of 2 times or 3 times the number of otherwise healthy 80 year olds who otherwise would have a life expectancy of perhaps 7 years except for the influenza. So we're faced with the ethical tension of are we trying to save the maximum number of lives when they are elderly at the end of life or the maximum number of lives when there may be fewer numbers of people but who have a longer life expectancy. And to what extent does that make the elderly vulnerable population, to what extent is it the right thing to do – to treat those who have a lot longer life ahead of them. These are the very precepts that are going to guide what we do and are confusing at least.

Dr. Berkowitz:

Well I think Ware that they are confusing to everyone. And anytime you get into a situation where you are valuing one life over another based on its quality if you will or some other inherent component of it, even if is potential years ahead, I think it's very difficult. It doesn't then get into the question of a sick 40 year old person versus an otherwise relatively healthy previously 75 year old. So age clearly alone is not a good criteria but should it be factored in?

Caller:

And should I also add how useful the person is to society. For example, if I have one of my physicians ill, I would want to save his life perhaps over an 80 year old because he can save more in the long run. So there are other factors to be considered but we also have to look at protecting our providers.

Dr. Berkowitz:

Absolutely. That's something that inevitably comes up in these discussions and the thinking again is complex. It's often saying that you protect first responders so that you can get them back into the line of duty. If the wave of the flu pandemic is expected to take roughly 4 weeks or so to pass through an area – that's a projection – and if the duration of illness might be that long until a person is ready to go back to work, you lose some of the ethical argument for putting health care providers at the head of the list and it's a very interesting question then, does the system owe providers something for putting themselves in harm's way at the outset. Do people have feelings about that? It's extremely controversial and I'd love to hear them.

Alice Beal, Brooklyn VAMC:

Has anyone looked at the DoD triage criteria because they are the one they are the one area must have specific triage criteria in the battlefield. I know it's a different situation.

Dr. Berkowitz:

I think it's safe to say that we've looked at a ton of other triage criteria that are out there. Certainly the DoD is unique in that they are based on sort of trying to get people back into the theater of battle. But I think the short answer to your question is yes we've looked at whatever we can find that's out there.

One thing that I'd like to get on before we finish the altered standards of care is that if we do end up denying patients critical services or life saving services, we

always come down to the fact that they'll still need to receive palliative or supportive care which then predictably will result in a very big surge for the need for palliative and supporting care services that we hope our system is ready for. And it will be a different thing for palliative care practitioners to be providing palliative care for patients who might not want it, who might want to continue aggressive care. And that I think is going to be a big shift for altering our standards of palliative care. I don't know if people want to comment on that.

Linda Williams, Little Rock VAMC:

As I've worked on our national decontamination training team and have considered the triage, how to do this has been one of my real interests and there are a few comments I'd like to make if I may. First of all, if we do have an influenza pandemic, we have to realize that this will be a new pandemic in humans that we really do not know once the virus has mutated how the lethality will be and so it's going to be very hard to make some decisions on withdrawing versus not starting the ventilator without having data and we really need to have in preparation a system for collecting that data so that we'll have some objective way of evaluating the decisions that are actually being made and that should be part of our triage planning process that I'm not sure we're thinking about.

Dr. Berkowitz:

I do actually, I think we're thinking about that and the recognition that depending upon the penetration and the severity of illness the different scenarios for a mild, moderate or severe surge, I think are all factored into the thinking that if things are bad, you'll have one rubric and if things are worse you'll have another, and if things are really severe then we're going to be forced into other areas of discomfort.

Linda Williams, Little Rock VAMC:

But I'm talking about actually tracking the outcomes so that if we're making the wrong decisions, we can identify that early.

Vickie Davey, Deputy Chief Consultant, Public Health Strategic Healthcare Group, VA Central Office:

There are plans for both a within VA influenza illness surveillance system as well as national plans for data collection.

Dr. Berkowitz:

I think that all of that is currently built into the system.

Vickie Davey, Deputy Chief Consultant, Public Health Strategic Healthcare Group, VA Central Office:

And I appreciate that comment.

Dr. Berkowitz:

Did you have anything else Linda before we get to professionalism for a few minutes.

Linda Williams, Little Rock VAMC:

Actually there are two other things that I have been thinking. First of all, is that I would like to be sure that as we prioritize these issues – professionalism, altered standards of care, or resource allocation – that before that we get to withholding and withdrawing, we actually do implement the altered standards of care because I think that they should take precedence over the withdrawing and withholding and I'm sure that that has been recognized, or at least I hope it has, but I think we need to make that a statement and a recognized fact that we would implement altered standards of care before we got to the point of implementing aggressively withdrawing or withholding. The other is that the issue that you brought up of palliative supportive care. I have been very concerned over the years that our basic triage system does not have what at one time the military system had in which I believe was a blue category which was when you recognized that someone is not dead but they are dying, that you triage them to a different category than the dead. The current military medical system and the START triage system, it's my understanding does not have the palliative care recognition. Those go in with the dead and the 'black' category and thus while someone is supposed to be with that group and re-triaged, that is not something that is done. I have wanted to see this system changed but it is a national triage system and I don't know if that can be an outgrowth of this ethical discussion.

Dr. Berkowitz:

One of our fundamental premises is that we need to design a system that is going to give humane care at whatever level the person is going to be getting. So yes, I think that that is something that we all recognize and that we're really working hard to make sure it gets incorporated and that that additional surge is recognized and planned.

Linda Williams, Little Rock VAMC:

The other comment I would have to make is to Palo Alto and the other places that are looking at these criteria. I know one of the standards for accepting altered standards of care and triage and is these will be publicly vetted and all of these stakeholders will have an opportunity to have buy in at the front end as the criteria are being planned and made known. I think that it is very important. For instance, the issue of aging. As a geriatrician who is also interested in triage, I've

looked at caregiver stress with making decisions for pediatric patients versus older patients and it is very difficult to withhold and withdraw care from a young child that comes in injured versus someone who is older and is perceived to have lived most of their life. And so you have to be very careful because the young child that has the life expectancy of one year from some known diagnosis of cancer or congenital heart disease may have less life expectancy than an 80 year old that is in very good health and still working with no limitations. So we have to be very careful that we have everyone at the table as we're planning these criteria.

Dr. Berkowitz:

The next topic we'd like to get into is professional responsibilities and I guess since time is getting short, rather than to talk about that right now, I did want to take a few minutes to suggest how facilities might begin that transparency and that front-loading about a dialogue about ethics concerns with their staff.

As we've said we know that we're all going to need to be making difficult and controversial decisions that will impinge on individual liberties in the event of a flu pandemic. The more that those that will be affected by those decisions can be informed about and involved in the decision making process, the more likely it is that the decisions will reflect a broad array of concerns and values and be better understood by those involved and probably be accepted.

So staff involvement in VA facilities pandemic preparedness planning is an important part of this open, transparent and inclusive process. So what we at the Ethics Center would like to suggest is that for those of who are currently working on ethics issues in flu preparedness and for those who are just beginning to think about it, is that you might want to consider holding a staff forum at your facility to begin a dialogue on issues of concern. Now we're going to be posting on our National Center for Ethics' website information that you can use as a basis for holding such staff forums and included in that information will be an explanation of the importance of the staff forums as a way to support transparency and openness in pandemic flu preparedness planning, some resources on how to hold such a forum, some PowerPoint slides that will provide you with a general overview about pandemic flu, a sample forum agenda, a sample forum brief overview and a handout on ethical values in influenza preparedness which includes 10 ethical values and examples of how these values apply in pandemic flu response and some sample discussion questions for forum participants.

Again, there is no mandate to hold staff or other forums on ethical issues but we think it might be helpful to use a resource such as this to consider the transparency and the inclusiveness in the process. So before we get to the end, I want to thank people who commented and I know there are a lot of other questions. We know that this is going to be shortened discussion to get to such complex issues so if you don't get to speak or ask your questions or comments

during the call, please email them to us at vhaethics@va.gov. But let's take a minute now to talk about professionalism, anything I mentioned about the staff forum, about the openness and inclusiveness, or things we've talked about before about people's sense of professionalism and how that duty to provide care is going to butt up against their expectations for their own safety and their own responsibility for their personal needs and their families.

Pat, Miami:

In discussions about this, one of the aspects of going beyond just talking about professional duty but looking at a recognition that if you've got a nurse who is a mother of three or a respiratory technician who is the father and supporter of his family, then we have to reward perhaps that duty to be there because our life insurances and our health insurances may not cover us and we may not even get a respirator so is there any discussion regarding rewards.

Dr. Berkowitz:

Well I think compensation for staff who put themselves in harm's way is certainly something that has been and will continue to be discussed.

Dr. Sharpe:

And there's also reference to that in the VA's Pandemic Influenza Plan. The ethical principle of reciprocity is what you're describing both in terms of helping staff to have the necessary protections to take on the additional risk and also ultimately to provide some sort of compensation for people who may be harmed while they are providing care to others.

Dr. Berkowitz:

We have about five minutes left on the call so if anyone has questions about the staff forums or the areas of professionalism, resource allocation or altering standards of care or if you have other ethics related issues on your mind now's the time to speak up in the last couple of minutes.

Are there things that staff feel would make it more likely that would keep coming to work in the event of increased risk in a pandemic flu or is the duty to care for our patients going to be enough to keep people coming? Do you think those expectations are different for clinicians and non-clinicians who we also need to keep the system running.

Caller:

One thing that has been discussed before is that if there are scarce resources such as vaccines and you offer them to people who come to work and their

families, people may elect to come to work in order that their family is protected. But unless we can protect their family, they are not going to come.

Caller:

I think one of the other key issues to think about in this whole pandemic situation is if this happens cities and states are going to shut down. The ability to get gas and things like that, it's hard to say whether the state or city levels would say stay home or what to do with that level but to know that there may be actually a hardship just to motorize a vehicle to work would become a problem.

Dr. Berkowitz:

Right and certainly the interaction of our facilities with the local community and the other health care agencies and local environment is going to be challenging and again that's addressed in the influenza and other emergency preparedness plans.

Caller:

Is there also discussion of sharing of staff across the network?

Dr. Berkowitz:

Well I think that redistribution certainly in events such as natural disasters such as Katrina, you try to redistribute your patients out of the area and you try to redistribute resources to where you need them. In an infectious epidemic it's very difficult to think about redistributing patients who may have the flu out. You may want to distribute other patients out. And certainly redistributing staff and other resources such as ventilators is certainly on the table. Again it's a little tricky because you don't know where the wave of the flu pandemic is going so you want to move things to where it is now and not leave people short where it's going to be. The answer though is yes – redistribution is very important.

Jamie Mackey, Muskogee VAMC:

In regard to your question earlier about whether people will show up, I believe it was in Minnesota, the Public Health Department has actually done a study on it, and if I remember the numbers correctly it was only about 50% that would actually come in the event of a pandemic like that. And what they found was that primary caregivers – nurses, doctors, etc. – that thought they had a difference to make in a patient's life would show up but auxiliary like clerical and things like that who didn't think that they could make as much impact, stayed home.

Dr. Berkowitz:

I think that's another advantage of the staff forum is to let everyone know the impact they will make. I mean certainly to have frontline providers here without support, without a way to get linens and supplies around, keep the place clean and sanitary and get food back and forth to the patients and providers and all the other support services, that's going to make us less able to take care of our patients so those support people are critical on a day by day basis as we work now and also would be critical if the system gets stressed. So that's another advantage of a staff forum.

Dr. Ware Kushner, Palo Alto:

One of the things that I think many have envisioned in the setting of a calamity is that it would necessarily affect clinicians' scope of practice and I think as commonly construed that may mean, for instance, nurses carrying out the duties normally performed by physicians or physicians needing to perform duties outside their customary clinical practice. But as we discussed the various multiple needs of a health care facility, it's clear that health care professionals may need to go way beyond their scope of practice to make sure that a hospital is functioning and able to meet the demands of a pandemic flu.

Dr. Berkowitz:

And again, that's clearly addressed in a general way in the VA Pandemic Flu Plan and is something that needs to be specifically addressed at the local level to make sure that people are indemnified and authorized to be practicing and how they will practice in the new arena and again will be indemnified for what they do. So another fly in the ointment Ware, thank you.

CONCLUSION

Dr. Berkowitz:

Well, as usual, we did not expect to conclude this discussion in the time allotted, and unfortunately we are out of time for today's discussion. We hope that we've informed you about our efforts to plan for ethical care during an influenza pandemic. We realize that there will never be a perfect plan, or perfect preparation, but we continue this effort with the belief that any planning we do will help to mitigate the effect of a pandemic or other stressors to our health system both for our patients and our staff. We will post on our Web site a very detailed summary of each National Ethics Teleconference. So please visit our Web site to review today's discussion. We will be sending a follow up email for this call that will include the call summary and the CME credits.

We want to thank everyone who participated in the development, planning, and implementation of this call, including Ashby Sharpe and Sherrie Hans, Vicky Davey, Connie Raab, and Amy Hertz in the Office of Public Health and Environmental Hazards, and Dr. Ware Kuschner. Also I would like to thank Michael Ford, Nichelle Cherry and other members of the Ethics Center and EES staff who support these calls.

- Let me remind you our next NET call will be on Wednesday July 26th at 1:00 ET. Please look to the Web site at vaww.va.gov/vhaethics and your Outlook e-mail for details and announcements.
- I will be sending out a follow-up e-mail for this call with the summary of this call and the instructions for obtaining CME credits.
- Please let us know if you or someone you know should be receiving the announcements for these calls and didn't.
- Please let us know if you have suggestions for topics for future calls.
- Again, our e-mail address is: vhaethics@va.gov.

Thank you and have a great day!

References

VA Influenza Preparedness Plan:

http://vaww.vhaco.va.gov/phshcg/Flu/pandemicflu_plan.htm